Texas Department of Insurance
Division of Workers' Comp
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

NISAL CORP
P O BOX 24809
HOUSTON TX 77029

Respondent Name

TEXAS MUTUAL INSURANCE COMPANY

Carrier's Austin Representative Box

Box Number 54

MFDR Tracking Number

M4-11-2714-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The workers' compensation carrier has issued a response to our facilities request for reconsideration which reads; services were not performed outside the normal scope of practice. Clearly all of our facilities documentation has been attached since initial faxing. Upon further review this documentation does indeed support the level of service billed."

Amount in Dispute: $200.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The requestor is George Grimes who submitted billing for a case management activity of 8/13/10 with code 99362-W1…Texas Mutual denied payment to the requestor for the following reasons.: "Rule 134.202(e)(B)(i) states that reimbursement to the treating doctor for code 99362-W1 is $198 and the modifier 'W1' must be added. The operative words here are 'treating doctor.' Which the requestor was not on the date of service. Texas Mutual's records identify the treating doctor was Donna Canlas, M.D., from 4/27/10 to present." "Code 99362 with the W1 modifier is reserved for the treating doctor. Dr. Grimes was not the treating doctor and has not been the treating Doctor."

Response Submitted by: Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, Texas 78723

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 13, 2010	99362-W1	$200.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 set out the fee guideline s for the reimbursement of workers' compensation specific services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated November 30, 2010
   - CAC-W1 –WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE.
   - DOCUMENTATION DOES NOT SUPPORT SERVICES PERFORMED WERE OUTSIDE THE NORMAL SCOPE OF PRACTICE FOR THE TREATING DOCTOR.

   Explanation of benefits dated March 8, 2011
   - CAC-W1 –WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 724 – NO ADDITIONAL PAYMENT AFTER A RECONSIDERATION OF SERVICES. FOR INFORMATION CALL 1-800-937-6824.
   - 744 – DOES NOT MEET THE DEFINITION OF CASE MANAGEMENT PER DWC RULE 134.202.

Issues

1. Did the service provided by the requestor meet the definition of case management under 28 Texas Administrative Code, Section §134.204?
2. Is the requestor entitled to reimbursement for the services billed?

Findings

1. 28 Texas Administrative Code, Section §134.204 (e)(1)(B) states, "Case Management Responsibilities by the Treating Doctor is as follows…Team conferences and telephone calls must be outside of an interdisciplinary program. Documentation shall include the purpose and outcome of conferences and telephone calls, and the name and specialty of each individual attending the team conference or engaged in a phone call." The team conference was initiated by George Grimes, Ph.D. and not by the treating doctor of record, Donna Canales, M.D. The disputed service does not meet the definition of case management.
2. Therefore, in accordance with Division rule at 28 Tex. Admin. Code §134.204(e)(1)(B), the Division concludes that reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 26, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.